



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization Drug Approval Form**

Verquvo®

DATE OF MEDICATION REQUEST:        /        /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

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GENDER:         Male         Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

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FAX NUMBER:

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**SECTION III: CLINICAL HISTORY**

- Does the patient have a diagnosis of heart failure with ejection fraction < 45%?         Yes     No
- Has the patient required use of intravenous (IV) diuretics in the past 3 months?         Yes     No
- Has the patient been hospitalized for heart failure in the past 6 months?         Yes     No
- Is the patient on guideline-directed therapy for heart failure?         Yes     No

List current therapy or note contraindication:

Beta-Blocker: \_\_\_\_\_

ACEi/ARB: \_\_\_\_\_

Mineralocorticoid receptor antagonist/aldosterone antagonist: \_\_\_\_\_

- Is the patient receiving a soluble guanylate cyclase (sGC) stimulator (i.e., riociguat) or a PDE-5 inhibitor (i.e., sildenafil)?         Yes     No
- If the patient is of childbearing potential, is the patient using contraception and has pregnancy been ruled out?         Yes     No



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DATE OF MEDICATION REQUEST:        /        /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION IV: FOR RENEWALS ONLY**

1. Has the patient demonstrated efficacy (e.g., symptom improvement, slowing of decline)?  Yes  No
2. Has the patient experienced any treatment-limiting adverse effects (e.g., symptomatic hypotension)?  Yes  No

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_